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Prelim Questionnaire

Please answer all questions applicable to the client's medical history. This is not an application for insurance and we will not order medical records until a formal application from one of our carriers is obtained,

Agent Name: _____ Phone # _____

State of Issue: _____ Are you licensed there? _____ Client's SS# _____

Client Name: _____ DOB _____ Sex M or F

Nicotine used within 60 months? Yes or NO If yes, type & date of last use: _____

Amount of insurance requested: _____ WL SUL UL Term _____ yrs.

1035X - Yes or NO Replacement - Yes or NO Life Settlement in last 4 years Yes or NO

Income\$ _____ * Net Worth **excluding Residence** \$ _____ Residence \$ _____
***(must be = or < than amount being applied for and insurance in force)**

Ins in force (Inc any policies settled to date) - \$ _____ Spouse \$ _____ Present Capacity \$ _____

Personally owned \$ _____ Trust owned \$ _____ Business owned\$ _____ Amount settled\$ _____

Has the case been submitted to other companies in the last 12 months? Yes or NO

If yes, list companies, dates, and action taken. _____

Dr Name: _____

Address _____

Phone _____

Has client seen a doctor within past 3 years? _____ If so, when & why? _____

What tests were done? _____

Results _____

Does client have a routine exercise program? _____ please describe: _____

List any medications, including over-the-counter medications or vitamins. Indicate dosage. _____

Height: _____ Weight: _____ any weight changes in past 12 months? If so, Reason & Amt _____

If Known:

Latest blood pressure reading: _____ EKG Results _____ Cholesterol/HDL Results _____

Family History: Has any family member (parents or siblings) had cancer, diabetes, high blood pressure, heart disease, or kidney disease prior to age 60? If yes, identify family member, disorder and age at onset.

Cardiac Disorders ~ Date of onset Treatment given

Angina (chest pain) - If yes – Treatment or Medications _____

MI (heart attack)? – If yes - Treatment or Medications _____

Irregular heart beat? – If yes - Treatment or Medications _____

Valve disorder? - If yes - Treatment or Medications _____

Name & address of cardiologist: _____

Date & reason last visit: _____

Date of most recent stress test: _____ Results: _____

Date of most recent echocardiogram: _____ Results: _____

Ever had:

Coronary catheterization? If yes - Treatment or Medications _____

Bypass surgery (CABG)? # of vessels - If yes - Details _____

Angioplasty (PTCA) # of vessels - If yes - Details _____

Valve surgery or replacement? Which valve? If yes - Details _____

Coronary artery disease? If yes - Details _____

Any current symptoms (chest pain, pressure, dizziness, blackouts, shortness of breath, etc.)? _____

If so, how often? _____

What medications is client taking (including over-the-counter, medications and aspirin)? _____

Does client carry nitroglycerin? _____ Date of last usage? _____

Copies of the catheterization reports, stress tests and echocardiograms will assist in evaluating the client's history.

Hypertension

Date of diagnosis: _____ Your average readings: _____ Do you monitor readings at home? _____

Medications: _____ Any other impairments? _____

Cancer

Type of cancer: _____ Location: _____

Staging: _____ Grading, or copy of pathology report: _____

Any positive lymph nodes: _____ Depth or level: _____

Date of surgery: _____ Any radiation or chemo? _____ If yes, date treatment ended: _____

Any recurrence of cancer: _____ Any other medical problems: _____

Substance Abuse

Date stopped using: _____ Duration used: _____ Kind of substance: _____

Amount used: _____ Type of treatment: _____

Attend AA or other programs: _____ Any relapses? _____

Are liver functions normal? _____ If no, give readings: _____

Any motor vehicle violations or DUIs? _____ If so, describe & give details: _____

Diabetes

Date diagnosed: _____ Treatment (oral meds, insulin, diet)? _____ # Units of insulin: _____
Regular doctor visits per year? _____
Any other medical impairments or complications: _____
Latest fasting blood sugar & date: _____ Latest glychemoglobin & date: _____

Asthma/COPD

When diagnosed: _____ Medication: _____ # of Attacks per year: _____
Date & severity of last attack: _____ Seasonal? _____
Any hospitalizations? _____ When? _____

Crohns/Colitis

When diagnosed: _____ Any surgery? _____ If so, what? _____
Current medication: _____ Date of last episode: _____

TIA/CVA Seizures (transient ischemic attack-ministroke/stroke)

Date of episode: _____ # of episodes: _____ Any residuals? _____
Type of treatment or medication: _____

Psychiatric

Diagnosis: _____ Date: _____ Medication: _____ Hospitalization(s): _____
Suicide attempts? _____ Currently employed? _____
Dr. Name and Address _____

Lab Abnormalities

What tests were abnormal? _____ Results & date: _____
Any diagnosis given? _____ How long has test been abnormal? _____

Aviation

Hours flown as Pilot or Co-Pilot: _____ Purpose (civilian, military): _____

Any Other Avocation

Please specify: _____

Any impairment not listed above

Diagnosis given and date: _____
Treatment: _____
Medications: _____
Date of last follow up: _____ Test results: _____

For clients with multiple medical conditions or cancer within the last 5 yrs or bypass/angioplasty or any conditions that may prevent a standard offer, please indicate the maximum rating or dollar amount we can work with to get as close to the desired face amount requested.

Please attach any information, i.e. - cover letter, financials, notes or medical requirements, etc. that you believe will assist us in accessing this case.